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ABSTRACT

The Lincoln Parish Family Planning Program, a 1968 pilot study designed in cooperation with the Louisiana State Board of Health, is described. The major purpose of the program was to design a program of medical care for the rural poor which would provide mothers in Lincoln Parish with information and services needed to plan family size. Sections of the document are devoted to (1) selection of site, (2) family survey for program design, (3) patient identification and contact system, (4) follow-up system, (5) summary of the findings, (6) discussion, and (7) preliminary effectiveness of a family planning program. It is noted that the results of the 2-year study imply that a rural area is, indeed, receptive to new ideas and to new concepts; that area personnel are willing to coordinate and to develop a local systematic program; and that local personnel can be trained to meet the challenges. The overall conclusion points out the need for better health services and health education for the rural poor. The document is appended with references, a figure, and 5 tables. (AN)

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ON

RURAL POVERTY

A REPORT ON

THE LINCOLN PARISH FAMILY PLANNING PROGRAM AND ITS IMPLICATIONS FOR REDUCING REPRODUCTIVE WASTAGE IN THE RURAL POOR*

by

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[1968]

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INTRODUCTION AND BACKGROUND[1]

The Lincoln Parish Family Planning Program is primarily a research laboratory in a rural public health setting which is used for population and family planning and maternal and infant care studies. In addition, the program is a pilot study for a proposed statewide system of publicly supported family planning clinics for the medically indigent population of Louisiana.

This pilot study was designed in close cooperation with the Louisiana State Board of Health and its staff. As such, it is a testing ground for administrative policies, clinic procedures, recruitment practices, and contraceptive methods.

One of the purposes of the program was "to design a medical care program which will provide mothers with the information and services needed to plan family size." Insofar as there were no organized family planning facilities in Louisiana, it was necessary to establish a laboratory for research on program design, implementation of services, and evaluation of program effects. Although the program is providing a service to Lincoln Parish residents, it is first and foremost a research operation.

The program's first priority was to obtain a legal status for a family planning clinic in Louisiana. All previous interpretations of Section 14:88 of the Louisiana Criminal Code made it a felony to disseminate any information about or service of birth control. Therefore, it was essential to have the legality of the Lincoln Parish proposal established. The opinion from the Attorney General's office, dated July 16, 1965, reversed the previous rulings on Section 14:88 and removed the legal barriers to the Lincoln Parish Program.

Following this legal ruling, the proposal was unanimously adopted by the State Board of Health on July 23, 1965. The proposal was then submitted to Governor John J. McKeithen. His approval was sought concerning facilities of

the State Board of Health, and the use of this program as a prototype for a state family planning program. The Governor's letter approving all propositions was dated July 27, 1965.

After all of the arrangements at the state level, the program needed an active acceptance by the regional counterparts. Therefore, formal approval and cooperation were sought and obtained from the North Central Louisiana Tri-Parish Medical Society, the Lincoln Parish Board of Health, and the Lincoln Parish Police Jury (county commissioners). In addition, the entire program was presented to religious leaders in the region. The general principles agreed upon by these various groups became guidelines for the clinic's operation.

It was only after these state, local, and church agreements had been reached that family planning services were added to the on-going public health care program of the Lincoln Parish Health Unit. The first clinic was held on September 10, 1965. During the Fall of 1965, only a small population of post-partum mothers were served in the clinic. However, by March, 1966, after the clinic forms and procedures had been established, the clinic was opened to all eligible women.

WHY LINCOLN PARISH?

The selection of Lincoln Parish as the site for the pilot family planning center was governed by its near "typical" rural characteristics. The criteria employed in the selection were:[2]

1) Its fertility and family planning problems were similar to those in most rural and semi-rural areas in the southern portion of the United States.

2) It is a complete governmental unit of a county or parish type and contained 25,000 to 50,000 people, but not a city with a population of more than 20,000.

3) Its population was between 30-60 percent nonwhite.

4) Its crude birth rate was about 20.

5) It had reasonably adequate medical personnel and medical facilities to draw upon, and the medical personnel was willing to cooperate in achieving the aims of the proposed program.

6) Its projected "clinic eligible" population was small enough to identify, contact, and provide service to the entire eligible population within a two-year period.

A demographic description of Lincoln Parish is provided in Table 1.[3]

FAMILY SURVEY FOR PROGRAM DESIGN

With no precedence, it was necessary to gather data from Lincoln Parish residents. This data survey was to answer such questions as:

1) Are the people knowledgeable but not motivated toward family planning?

2) Are they already practicing contraception, if so what kind?

3) Do they desire information about it?

In addition to gathering data on the residents' motivation for and knowledge of family planning we needed information on such variables as family structure in this area. Our data were acquired through a probability sample, a description of which appears in the appendix, of couples who had had a child during the last five years -- 1960-1965.

Although we gained extensive information from this survey; here, we will deal with data pertinent to family planning and reproductive wastage. The survey produced the following insights about the total population:[4]

1) 87 percent of the women and 82 percent of the men did not know enough

about the ovulatory cycle to know that the fertile period is approximately the middle 7 days between two menstrual flows.

2) 47 percent of the women and 37 percent of the men did not know that pregnancy results from the union inside the woman of a male sperm with a female ovum.

3) 15 percent of the women and 3 percent of the men did not know of any natural, mechanical, or chemical methods of preventing conception; and another 19 percent of the women and 40 percent of the men knew of only one method.

4) 71 percent of the women and 66 percent of the men said they desired more information about family planning methods; another 21 percent of the women and 32 percent of the men said they had sufficient knowledge of family planning methods or were sterile or in a sterile union.

5) 96 percent of the women and 87 percent of the men said that they believed that couples had the right to decide for themselves when to stop having children.

6) 99 percent of the women and 98 percent of the men said they believed that family planning services should be provided for the medically indigent.

The differences between the socio-economic classes are illustrated below:[5]

1) A sizable proportion of all socio-economic classes were not knowledgeable about reproductive physiology, but ignorance concerning reproductive physiology was more marked in the lower socio-economic class. For instance, 97 percent of the women in the lower class did not know that the "fertile" period is approximately the middle seven days between two menstrual flows.

2) Over 90 percent of the women in the middle and upper socio-economic groups were utilizing an effective and scientifically acceptable family planning method, as compared to less than 50 in the lower socio-economic

class. Further, the method used by the lower class women were the least effective and their usage was eratic.

3) Eighty-four percent of the lower socio-economic group desired more information about family planning and 97 percent were in favor of family planning services being provided for the medically indigent in Lincoln Parish.

There results are similar to the trend found in an earlier survey conducted in New Orleans. It seemed that the lower socio-economic segment of the population exhibited motivation toward family planning service, but this motivation was frustrated by a lack of information about and facilities for family planning services. Based on this data, the design of the Program was premised on the hypothesis that motivation already existed and that what was needed was adequate information and services. The program's emphasis was, therefore, on identifying, contacting, education, providing services, and developing a follow-up system.

PATIENT IDENTIFICATION AND CONTACT SYSTEM[6]

Since the data indicated a lack of awareness of family planning, it was necessary to design a program which could reach the patient in order to inform her. To effectively carry out and evaluate the program these categories of population were essential:

1) The "medically indigent," and of the "medically indigent,"
2) The "identifiable" or the "not identifiable," and of the "identifiable,"
3) The "available" or the "not available," and of the "available"
4) The "accepting" or "rejecting" patients, and of the "accepting" patients,
5) Those who "continue" or those who "discontinue" using the services.

Figure 1 illustrates the rationale of patient identification.

The population of Lincoln Parish in 1965 was estimated to be 30,300 with 6,730 females of age 15 to 44. The greater need for family planning information and service existed in the lower socio-economic group who received their medical care from the existing tax-supported system. There was no way to determine the exact size of the medically indigent female population age 15 to 44, but an estimate from census data indicated there were 2,500 female Parish residents in this category. Of the births in Lincoln Parish, 97 percent occur in hospitals, 3 percent occur at home. Of the births in Lincoln Parish, 44 percent are medically indigent and occur in 3 State hospitals located within a seventy-mile radius of Lincoln Parish. For study purposes the medically indigent was defined as those patients who met the following criteria.

1) Any patient who had delivered a live birth or a stillbirth at one of the three charity hospitals nearest Lincoln Parish, or at home, during 1960-65.

2) Any patient who delivered a live birth or stillbirth at home or at one of the three charity hospitals nearest Lincoln Parish, after the program was initiated.

3) Any patient who met the financial eligibility criteria necessary for delivery in the Charity Hospital system but who had not yet experienced such an event.

A. "Not identifiable" indigent population

The "not identifiable" segment of this population was defined as those patients who met criteria No. 3 above, or who qualified financially but could not be identified through vital records. We do not currently have a system for identifying this population. The present program design only allows for identification of medically indigent patients of recent proven fertility. We are currently attempting to develop a system by which the rest of the medically indigent population can be identified.

B. "Identifiable" medically indigent population

This group is identified by hospital referrals and by vital records of the Louisiana State Board of Health. This population size changes with time since all current births are added to and some patients deleted from this category. Therefore, this group of 961, was defined within a point in time as the "identifiable" medically indigent population as of January 1, 1966.

Some patients have greater needs for, and are more likely to use, services than others. Therefore, the group has been divided into sub-groups. Each member of the population was assigned to a sub-group on the basis of such attributes as risk status and recency of last pregnancy. Although the attributes are not mutually effective, the assignments to "high risk" and "low risk" sub-groups are mutually exclusive for administrative reasons.

a. "High Risk"

The "high risk" group consists of women for whom a relatively high probability of danger would exist to mother or child in the event of another pregnancy. Because this group is identified through the vital records, the criteria for "high risk" are limited to factors included in the vital records. A woman is classified as "high risk" if she possesses one or more of the following characteristics:

1) Women who have given birth to six or more children.
2) Parous women who are currently under age 17 or who are over age 39.
3) Women who have had one or more stillbirths.
4) Women whose latest delivery was a liveborn infant weighing five pounds and eight ounces (2,492 grams) or less.

5) Women with a history of infant or child death.

6) Women whose last birth was out-of-wedlock.

7) Women whose latest birth was a multiple birth.

In Lincoln Parish more than half of the "identifiable" medically indigent population were classified as "high risk" by these necessarily crude criteria.

b. "Low Risk"

The "low risk" group consists of members of the "identifiable" medically indigent population who were not classified as "high risk." Contact of "high risk" women takes priority over that of "low risk" women.

C. "Available" and "not available" identifiable medically indigent population

From this "identifiable" population a number of people who, while they would not be denied the services of the clinic, would be highly unlikely to use them. Such persons may be "not available" for clinic services because they may be presently pregnant, sterile, or no longer live in Lincoln Parish.

Classifying the "available" individual or patient involves gathering information from her. Specifically, this information includes her current fecundity, practice of birth control, and her attitudes toward the practice of birth control. The source of referral determines the manner in which this information is obtained.

a. Post-partum and "identifiable" not immediately post-partum referrals.

This group of patients was given the highest priority in program design. The post-partum period is a crucial one for the adoption of family planning. It is possibly the time when the woman is most highly motivated to consider family planning. Employees of the three Charity Hospitals have been enlisted and trained to refer Lincoln Parish maternity patients to the Clinic. In addition, all deliveries occurring at home are registered when the parents request a birth certificate and a home visit is made to each of these patients

by a public health nurse. At the time of the hospital or home post-partum contact, family planning is explained to the patient, she is given literature, and is offered an appointment to the post-partum family planning clinic. Other than the information imparted, no attempt is made to motivate the patient to attend the clinic.

b. Other referral procedures.

Members of the "identifiable" medically indigent population are also identified and referred by public health nurses, welfare workers, physicians, clergy, and friends or relatives.

c. Self-referral

A member of the medically indigent population may become "identifiable" by contacting the clinic on her own initiative, presumably as a result of knowing someone else who has attended the clinic or has been contacted by clinic personnel.

If the individual has been identified through the vital records, the information is obtained from her by a nurse during a home visit. If she has been identified by a hospital referral agent, health unit nurse, or welfare worker, the agent obtains the information in the course of referral and sends it to the clinic. If the individual personally contacts the clinic, the information is obtained from her at that time. In this manner, members of the "identifiable" medically indigent population who are "available" for clinic services, are offered an opportunity to accept or to reject participation in the program.

In the clinic, all patients receive instruction on: (1) the meaning of family planning and its relationship to family welfare; (2) the mechanism of fertilization and subsequent fetal development; (3) the types of available medically sound birth control methods and the advantages and disadvantages of each; and

(4) the official positions of the larger religious denominations in respect to family planning. After this comprehensive instruction, all patients have the opportunity, in private consultation with a clinic staff member, to decide individually which birth control method they want to use, if any. Similarly, patients who elect the use of a contraceptive are provided with the appropriate equipment, instruction, and service. Since the program was developed as an integral part of a comprehensive maternal health service, all patients receive a pelvic examination, a cervical smear for cancer detection, and, when appropriate, a post-partum evaluation.

FOLLOW-UP SYSTEM[7]

In the event a patient accepts an appointment to the clinic and then fails to keep the appointment, the procedure routinely implemented is:

a. When the first appointment is missed, a clinic employee will telephone the patient, if possible, and attempt to arrange another appointment. If the patient cannot be reached by telephone, a postcard is sent setting a date for an appointment.

b. If the patient misses the first rescheduled appointment, a postcard is sent giving another appointment date.

c. If the patient misses the second rescheduled appointment, a staff member from the clinic visits the patient at home and offers another appointment.

d. If the patient is wearing an IUCD, and if she misses the third rescheduled appointment (steps a, b, and c above), a clinic nurse will make home visits at three-month intervals to inquire about the patient's status. If the patient is not wearing an IUCD and breaks a third rescheduled appointment, her records are placed in the "inactive"file.

e. At any juncture, a patient may call in before one of these follow-up contacts is made and ask for an appointment. This is called "self follow-up."

SUMMARY OF FINDINGS TO DATE[8]

Table 2 shows data for those post-partum patients contacted at the three charity hospitals referring patients to the Lincoln Parish Family Planning Clinic during the first eight months of full-scale program operation. No one refused to accept a clinic appointment. Of the 141 women whose appointment was due on or before November 10, 1966, 110 or 78 percent kept their appointment, 11 percent are still in the follow-up cycle, and only 11 percent did not keep their appointment.

The second highest priority for determination of contact was the "high risk" segment of the population. As shown on Table 3, 600 women or 62 percent of the 961 identifiable medically indigent women are "high risk" by program definition. This includes 310 women, or 32 percent of the total, with illegitimate births.

As shown on Table 4, 543 women or 56 percent of the total identifiable medically indigent population was contacted by November 10, 1966. Of this number, 367 or 67.6 percent were classified as "available" and 176 or 32 percent were classified as "not available."

A total of 250 or 68 percent of the 367 "available" patients kept their appointments at the Family Planning Clinic. If 68 percent of the 50 patients still in the "follow-up cycle" keep their appointment, this would mean that 34 additional patients of the "available" group will keep their appointment. Adding this 34 patients to the 250 patients who have already kept their appointment, it would show that 284 or 77 percent of the "available" patients

kept their appointment.

The 418 patients or 44 percent of the total identifiable medically indigent population not contacted by November 10, 1966, represent the balance of the "high risk" patients, most of the "low risk" patients, and a segment of the 1965 population which were held out for experimental purposes. These have now been contacted and these data will be available in a few months.

As shown on Table 5, 183 or 54 percent of the 341 patients who attended the clinic at least once, reported that they had used no family planning method during the six months prior to the time of their first clinic appointment or, in the case of post-partum patients, during the six months prior to their last pregnancy. The methods reported by the group which had used contraception were condom (17%), jelly, cream, or foam (14%), and pill (6%). Eight months after full-scale operation was initiated, 87 percent of the same 341 women were using some method of family planning, 27 or 8 percent were lost to follow-up, and 16 or 5 percent were using no method of family planning. The IUD was the most popular method with 187 users (55%), and oral contraceptives the second most popular method with 68 users (20%). There was a marked change as a result of the program in both the number of patients using family planning and in the type of method used among those who had previously used some method.

DISCUSSION

One important fact, demonstrated in this research is that with personnel and with facilities indigenous to an area, a highly sophisticated and effective health program of a difficult nature was carried out. Furthermore, our results imply that a rural area is, indeed, receptive to new ideas and to new concepts; that area personnel are willing to coordinate and to develop a local systematic

program; and that local personnel can be trained to meet the challenges. They do, however, require central-coordinating direction. Inasmuch as the only "artificial" aspect of this program was the "importing" of the program design, or coordinating direction and funding, the basic design can be developed to be introduced into other areas and easily applied according to each's available resources and facilities.

Although it is still too early to foretell the exact or statistical impact of some variables which need to be measured over a long term, it does appear, nonetheless, that the success of the family planning program as well as the immediately feasible, better organized, and more comprehensive maternal and infant care program has had a considerable impact on the area even at the end of a 14 month period.

Having listed many of our preliminary findings which could be termed "successful," let us now look at the findings which illuminate persistent and remaining problems:

1) Inadequate funds available for physicians' fees

It would be simple to refer patients to private physicians for comprehensive care on a contract basis and to pay the physicians for this service. However, there is no way of doing this at the present time except through Title 19, which affected less than 10 percent of these families in the Lincoln Parish area. Hence, there is no method by which comprehensive care can be provided in the local area.

2) Two vastly different medical-care systems are maintained to service a small population.

A separate system, vastly different from that conducted by private

physicians for the middle and upper socio-economic groups, is conducted for the poor or indigent group. The medical-care system for the poor population is fragmented, segmented, less personal and less effective in reducing sickness and death. Because of its fragmentation, this sytem of medical care is presently incapable of providing comprehensive care in the local area. As pointed out earlier, 43 percent of the families of Lincoln Parish are excluded from the "private" facilities for care in the area and are forced to seek medical care as much as 70 miles away.

3) The medical-care system conducted for the poor has no central-coordinating or comprehensive patient-care unit.

Although we obtained coordination and cooperation from the various participating agencies, there is no central authority which can evolve and implement a health plan nor insure an effectual and perpetual long-term program. This research program had to contact and to relate to each of the various cooperative agencies independently, as each agency's policies, overall planning, and allocations go on distinctly separate from that of the other agencies involved in delivering health-care to the community. (The Comprehensive Health Services Bill HR749, if properly interpreted and implemented at the state level, could remedy this situation at the parish or county level.) However, because of its current fragmentation, this system is currently unable to supervise or execute total comprehensive medical-care.

4) Preventative education, one of the basic patient needs, is missing

No education or "preventative-care" facility exists for the entire

family of the indigent population. For example, the children currently coming into the reproductive-age group and forming families are offered no preventative education within this fragmented medical system. Also, parents without information and knowledge are incapable of educating their children; nor is such information available within the current school system. For this reason, the medical-care system continues to treat problems only after they have arisen rather than preventing their occurrence. Although we are preventing some problems with the family planning program, we see the woman who becomes pregnant out-of-wedlock only after she is pregnant. Therefore, without preventive education facilities, the fragmented system is effective only within a segment of the population.

In addition to the inability to reach the "developing" generation, a family planning program within a segmented medical care system omits an integral part of its overall program, the male family-head. We have tried to involve the male populace through literature for him about the program. Our literature explains what we are doing and why and invites his questions and participation. Yet, our only means of presenting this information is through the female patient. Our subsequent data revealed that, in most instances, there had been little previous communication on sexual matters between the male and female components in the family and that the female remains most reluctant to discuss the program, even the literature, with the male. As a result, many of the males not only do not receive our literature, they do not know that the female is practicing some form of contraception, while they remain generally uninformed about the

overall program and of its intent.

This basic lack of communication is evidenced in our motivational statistics on the male population which indicate that the males are equally as ignorant but equally as interested in information about family planning techniques as are the females. Frequently, the subject is one about which the male and female have not communicated and continue to remain silent with each other. Yet, adequate methods of reaching and educating the males must be developed; otherwise, contraception practiced by the female, but without the full knowledge and consent of her male counterpart, can only offset the "increased family compatibility."

5) An inability to control or to correct the basic environment into which the well patient is returned

For example, because of the lack of education, a young mother may not realize that diarrhea in an infant is a serious problem. Therefore, the lack of education, as well as the lack of facilities necessary to refrigerate or sterilize milk may result in serious illness or in death regardless to the type of medical care previously given the child. For instance, adequate attention must be given such basic factors as housing. There is very little one can do for a child after he develops a form of encephalitis carried by the mosquito, or nephritis resulting from mosquito bites and developing secondary skin lesions. In many instances, these complicated and dramatic diseases develop because the child has been bitten so often by mosquitos in a house without screens, in mosquito infested swamps or forests.

6) The poor patients face unique problems in seeking medical care

The poor patients face unique problems in seeking medical care: problems of lack of capital for transportation, buying drugs or any other health applicances, time off work for check ups or extended treatment, costs of child care during absence for medical appointments. Too often these costs will prohibit a patient's seeking medical care, especially such care as preventive treatment.

Although we have conducted a significant demonstration program in Maternal Health and Family Planning and although we have derived the mechanisms which could extend this coordinated program to any other area, we have not solved the problem of the split between preventive and curative medicine. And without effective, sophisticated diagnostic-outpatient treatment facilities, along with preventive family health services, the split between so-called preventive care and curative care continues to widen. The fragmented medical services are inadequate, costly and a duplication of total effort as well as ineffectual in reducing the vast amount of reproductive wastage.

As a result of our two-year experience in this rural parish, an important fact was brought to light:

> Granted all the imperfections of medical care within the private sector of medicine, even in a rural area, the statistics are remarkably low for the middle and upper economic groups, especially the white population. In the rural environment roughly 50 percent of the current reproductive wastage occurs in less than one-third of the rural population, the lower socio-economic group.

PRELIMINARY EFFECTIVENESS OF A FAMILY PLANNING PROGRAM

In essence, the overall design of the Lincoln Parish Family Planning Program was predicated on the Lincoln Parish Family and Fertility Survey data. This data indicated that marked ignorance of and a misconception about family planning existed, especially in the medically indigent families. Paradoxically, however, the couples appeared to be strongly motivated for such information and service. The program design, then, premised that the provision of adequate family planning information and service would result in a high level of acceptance of such services by this population.

Furthermore, evidence indicated that the indigent "high risk" mother contributes disproportionately to the infant mortality and premature rates. Therefore, should this "high risk" population be identified, offered family planning, and given effective methods of contraception, a significant reduction in the infant mortality rates should result.

Since such a large majority of this population accepted the program's services and now practice effective family planning techniques, a decrease in the Lincoln Parish infant mortality and stillbirth rates is indicated and should become evident during the second and subsequent years of the program.

While it is true that a decrease in the rates of infant mortality and stillbirth alone would justify a family planning program, accompanying "reproductive wastage" rates must also be examined.[9] For example:

1) Reducing the number of births occurring to "high risk" mothers after a desired family size has been achieved will reduce the number of premature births.

2) Reducing the number of premature births, a major factor associated with mental retardation, will reduce the incidence of mental retardation.

Yet, aside from the actual mortality tables, an effective family planning program within the indigent population will undoubtedly alter the most pressing problem faced by any medical system treating this population: the environment into which the mother and child (or patient) is returned. Therefore, an increase in the proportion of women within the indigent population practicing family planning will result in:

1) A proportionate reduction in the illegitimacy rate.
2) A proportionate reduction in the number of non-nuclear or broken homes. Inasmuch as the proportion of "desertions" by the family head is related to the number of children and his inability to support them, a reduction in the number of children to support would lessen the burden and lessen the number of "escapees" from that burden.
3) An enhancement of the marital compatibility of existing nuclear families.
4) Primarily increasing the family's ability to do MORE for the fewer number of children.

Accepting the effectiveness of a family planning program in reducing the current birth rates, maternal and infant mortality rates, premature and mental retardation rates, illegitimacy and non-nuclear family rates, one must concur additionally with the effectiveness of the program upon the livelihood of the individual patient and of her family unit. Yet, the effect of such a program extends beyond the statistical decrease in human death and reproductive wastage, as well as beyond the welfare of the individual patient. The effect of such a program may eventually be measured in disproportionate economic savings to public health and welfare programs, or to society in general. For example, if $1,000 can prevent the birth of one mentally retarded child, the care for which will cost the public as much as $100,000, the savings will indeed be disproportionate, both in human and economic terms.

Given the rural poor's existing, inadequate and fragmented care system as well as the repercussions of the rural-poor environment, our society needs to assign utmost priority to the immediate provision of total or comprehensive health service for these citizens. However, family planning is the segment of health care which will have the greatest impact on reproductive wastage in the rural poor for the least expenditure.

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2. Taken from: Vestal W. Parrish, Jr., Jill Kaplan, Carl L. Harter and Joseph D. Beasley, "Family Survey of Lincoln Parish: Instruction Manual," mimeographed, Center for Population and Family Studies, Tulane University School of Public Health and Tropical Medicine (New Orleans, Louisiana) pp. 1-2.

3. This table was prepared by Carl L. Harter and is included in: Ibid. pp. 2-3.

4. Reported in: Joseph D. Beasley and Carl L. Harter, "Introducing Family Planning Clinics to Louisiana," CHILDREN, 14 (September-October, 1967), p. 190.

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6. Ibid.

7. Ibid.

8. Ibid.

9. For a description of a Family Planning Program designed to test some of the following hypotheses, see: Joseph D. Beasley, "The United States: The Orleans Parish Family Planning Demonstration Program (New Orleans, Louisiana)" A paper to be published in The Population Council's STUDIES IN FAMILY PLANNING.

Figure 1. Rationale of Patient Identification

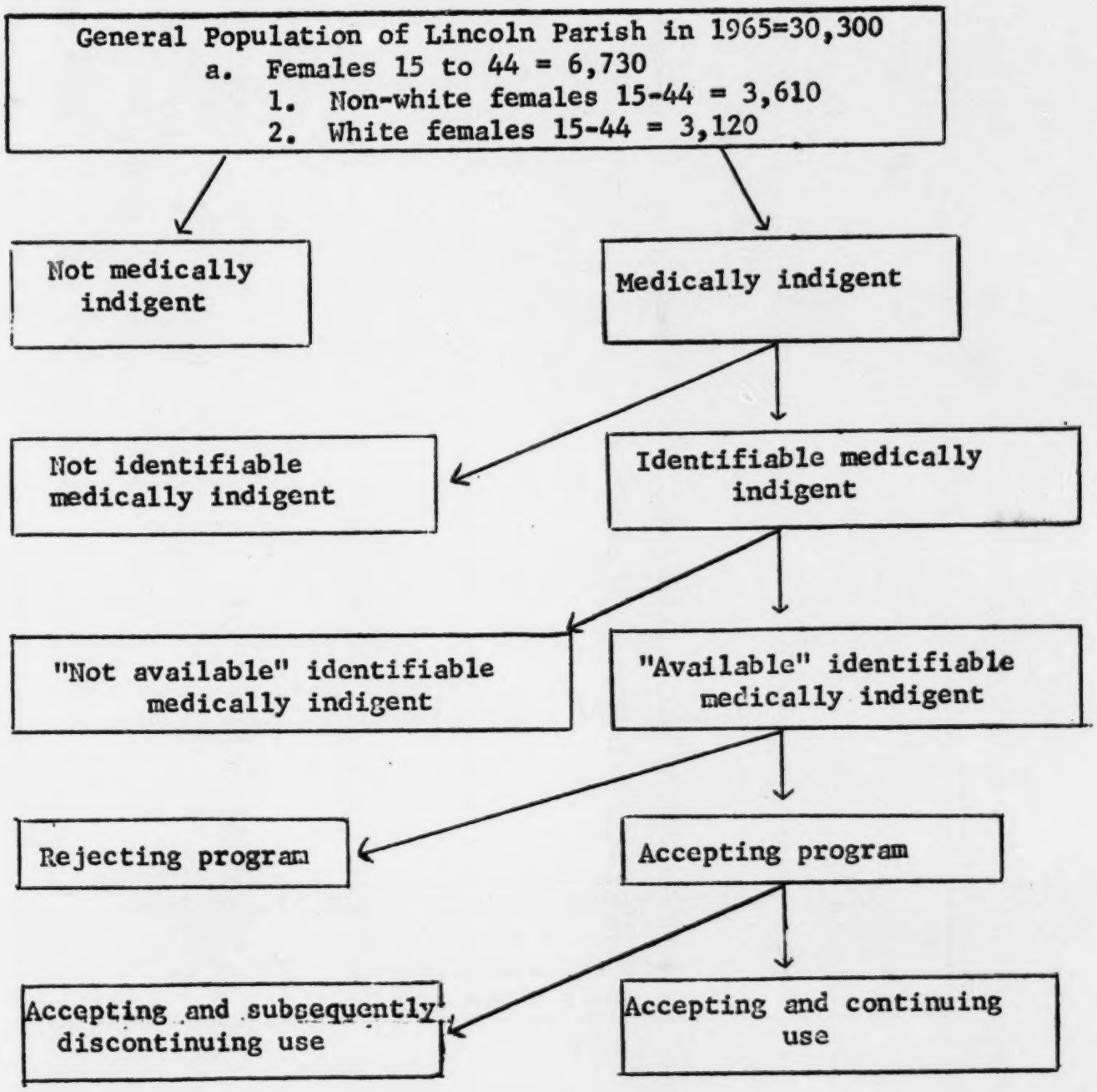
General Population of Lincoln Parish in 1965=30,300
a. Females 15 to 44 = 6,730
1. Non-white females 15-44 = 3,610
2. White females 15-44 = 3,120
Not medically indigent
Medically indigent
Not identifiable medically indigent
Identifiable medically indigent
"Not available" identifiable medically indigent
"Available" identifiable medically indigent
Rejecting program
Accepting program
Accepting and subsequently discontinuing use
Accepting and continuing use

TABLE 1

DEMOGRAPHIC DESCRIPTION OF LINCOLN PARISH, LOUISIANA

Population of Lincoln Parish, 1960

Place of Residence	Nonwhite			White			Total		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Total									
Number	5,461	6,480	11,941	8,517	8,077	16,594	13,978	14,557	28,535
Percent	19	23	42	30	28	58	49	51	100
Urban									
Number	3,128	3,974	7,102	5,259	4,774	10,033	8,387	8,748	17,135
Percent	18	23	41	31	28	59	49	51	100
Rural									
Number	2,333	2,506	4,839	3,258	3,303	6,561	5,591	5,809	11,400
Percent	20	22	42	29	29	58	49	51	100

Birth Data for Lincoln Parish, 1960

Birth Data	Nonwhite	White	Total
Females Age 15-44	3,274	3,418	6,692
Live Births	295	311	606
General Fertility Rate	90	91	91
Crude Birth Rate	25	19	21

Table 1 (continued)

Infant Death Statistics for Lincoln Parish, 1959-1963

YEAR	Live Births			Neonatal Death			Neonatal Death Rate			Infant Deaths			Infant Death Rate		
	W	NW	T	W	NW	T	W	NW	T	W	NW	T	W	NW	T
1959	332	315	647	4	11	15	12	35	23	8	17	25	24	54	39
1960	311	295	606	3	6	9	10	20	15	3	10	13	10	34	21
1961	308	304	612	4	7	11	13	23	18	4	10	14	13	33	23
1962	291	310	601	9	15	24	31	48	40	11	20	31	38	65	52
1963	278	311	589	5	14	19	18	45	32	5	19	24	18	61	41
Yearly Average 1959-1963	304	307	611	5	11	16	16	36	26	6	15	21	20	49	34

Additional 1960 census information about Lincoln Parish:

1. There were 7,103 households, an increase of 11.6% from 1950, of which 34.4% were nonwhite. Each one contained an average of 3.46 persons.

2. There were 236 marriages in 1960.

3. Of the persons age 25 and over, 45% had completed high school, but 15% had completed less than five years of school. The median education level was 8.8 grades.

4. The median family income was $3,477 and 44% of the families had incomes below $3,000. The median family income for the nonwhites was $2,156.

TABLE 2

NUMBER AND PERCENT OF HOSPITAL POST-PARTUM REFERRALS: MARCH - NOVEMBER, 1966

	Number	Percent
Total	141	100.0
Number keeping or not keeping appointment	126	89.4
Kept appointment	110	78.0
Did not keep appointment	16	11.4
In follow-up Cycle	15	10.6

TABLE 3

NUMBER AND PERCENT OF MEDICALLY INDIGENT POPULATION, BY RISK STATUS: LINCOLN PARISH, 1960-65

RISK STATUS	NUMBER	PERCENT
Total	961	100.0
High Risk:		
Age	89	9.3
Illegitimate birth	310	32.3
Premature birth	168	17.5
Stillbirth	30	3.1
Infant death	52	5.4
Multiple birth	17	1.8
High parity	231	24.0
All high risk*	600	62.4
Low Risk	361	37.6

*Less than sum of individual categories because some women appear in more than one category.

NOTE: Data from birth certificates on file in Louisiana State Health Department

TABLE 4

NUMBER AND PERCENT OF MEDICALLY INDIGENT POPULATION, BY AVAILABILITY STATUS: LINCOLN PARISH, 1960-1965

AVAILABILITY STATUS	NUMBER	PERCENT
Population	961	100.0
Contacted	543	56.5
Not Contacted	418	43.5
Contacted	543	100.0
Available	367	67.6
Kept appointment	250	46.1
Did not keep appointment	67	12.3
In follow-up cycle	50	9.2
Not Available	176	32.4
Sterile	59	10.9
Pregnant	21	3.9
Moved	96	17.6
Available	367	100.0
Kept appointment	250	68.1
Did not keep appointment	67	18.3
In follow-up cycle	50	13.6

TABLE 5

NUMBER AND PERCENT OF CONTRACEPTIVE USERS BY CONTRACEPTIVE METHOD: BEFORE AND AFTER ATTENDING LINCOLN PARISH FAMILY PLANNING CLINIC

CONTRACEPTIVE METHOD	Before attending FPC		After attending FPC	
	NUMBER	PERCENT	NUMBER	PERCENT
Total*	341	100.0	341	100.0
IUD	0	0	187	54.8
Orals	22	6.5	68	20.0
Rhythm (safe period)	2	0.6	0	0
Condom	59	17.3	2	0.6
Jelly/cream/foam	47	13.8	40	11.7
Other	28	8.2	1	0.3
No contraception	183	53.6	16	4.7
Lost to follow-up	n.a.	-	27	7.9

*Less than sum of "kept appointment" categories on Tables 2 and 4 because some women appear in both categories.